PRINTED: 11/19/2008 FORM APPROVED OMB NO. 0938-0391

	EMENT OF DEFICIENCIES (X1) PF(OVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	09G183		B. WIN	NG		10/31	/2008
NAME OF PE	ROVIDER OR SUPPLIER			4	EET ADDRESS, CITY, STATE, ZIP CODE 414-16 JAY STREET, NE VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE	(XS) COMPLETION DATE
W 000	October 29, 2008 of the fundamental showever due to color and Active Treatment in those areas. A random sample from a residential one male with medisabilities. The sobservations in the program, interview including unusual. On October 29, 20 that staff's conducting breakfast pathreat to their hear facility's Qualified Professional (QM notified that an impulementing the identified concern further potential hand the alleged abust leaving pending the	trivey was conducted from through October 31, 2008. Survey process was initiated incerns in Client Protections tent, the survey was extended of two clients was selected population of three females and intal retaindation and other urvey findings were based on a group home and at one day we and a review of records, incident reports. 208, a determination was made at towards Clients #2 and #3 loosed an immediate and serious lith and safety. At 4:32 PM, the Mental Retardation RP) and Program Director were imediate jeopardy existed. The don site until the facility mediate jeopardy by following plan to alleviate the is and protect the client's from	W	000	GOVERNMENT OF THE DISTRICT OF HEALTH REGULATION ADMINI 825 NORTH CAPITOL ST., N.E., WASHINGTON, D.C. 200	OF COLUMBIA TH STRATION 2ND FLOOR	
ARGRATO	leave pending the and - all remaining sta 31, 2008 on abus	ere placed on administrative outcome of an investigation; aff will be in-serviced by October and neglect, incident	NATIN	F	TITLE		(XS) DAYE
	tte S.	iore Director of	Le Tre	- ei	destral Terrices	_/2-5	-08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that afeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days by the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 tays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MOY011

Facility ID: 09G183

MTS (X4) ID PREFIX TAG	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
MTS (X4) ID PREFIX TAG	09G183		B. WING			10/31/2008	
PRÉFIX TAG	OVIDER OR SUPPLIER			44	EET ADDRESS. CITY, STATE, ZIP COD 114-16 JAY STREET, NE /ASHINGTON, DC 20019		
W 000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 104	Behavior Support As a result of the made that the fact the Condition of J Client Protection. 483.410(a)(1) GC The governing be budget, and oper This STANDARD Based on observe record reviews the ensure that the fact and operating dir. 1. Cross Refered body failed to ensimplemented to ensure that the fact of the verbal, physical mistreatment. 2. Cross Refer to failed to ensure source were immediated to ensure source were immediated to ensure source were immediated.	ne protocols, and Client #2's Plan (BSP). findings, a determination was cility failed be in compliance with Participation requirements in OVERNING BODY ody must exercise general policy, ating direction over the facility. Dis not met as evidenced by: ations, staff interviews, and he governing body failed to acility exercised general policy, ection over the facility.		104	Conditions Out 12-2-08 W104 MTS has made the system correct the issues that caused the Client P out of compliance as evidenced by throughout and particularly, the re W153, W154, W369 and W392.	rotections condi- y the responses	tion 10 be
	body failed to pro	nce to W154. The governing byide evidence that all incidents of unknown origin had been tigated.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		09G183	B. WNG		40/2	10/31/2008	
NAME OF P	ROVIDER OR SUPPLIER		}	REET ADDRESS, CITY, STATE, ZIP 4414-16 JAY STREET, NE WASHINGTON, DC 20019		1/2000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(XS) COMPLETION DATE	
W 104	Cross Reference body failed to ensu prescribed medica Cross Reference body failed to ensu	te to W369. The governing that clients received all tions without error. The governing that discontinued removed from the clients supply.	W 104	·			
	This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure entries into the clients records were signed for two of the two clients included in the sample. (Clients #1 and #3) sheet that the RN signs for signed that sheet (see: attait the RN signs for signed that s			The RN has placed a post-date quarterly nursing examination sheet that the RN signs for each signed that sheet (see: attached instructed to insure that she rot review document itself 12-2. The QMRP will review the me insure mutine compliance 12 The IXON will also audit the	sh quarter. The nurse he quarter. The nurse he i), however, the RN he utinely signs the quarter. dical records monthly	ed ad as been erly	
	a. Interview with the on October 29, 200 revealed that she (nursing examination medical record review dated October 30, 200 revealed that she (nursing examination medical record review dated october 30, 200 revealed that she (nursing examination medical record rev	stered Nurse (RN) failed to sign a quarterly reviews. The facility's Registered Nurse (RN) completed quarterly ons. Review of the Client #1's realed a nursing quarterly over 22, 2008 that was not the facility's Registered Nurse (RN) completed quarterly ons. Review of the Client #2's realed a nursing quarterly ons. Review of the Client #2's realed a nursing quarterly of the Client #2's r					

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA ICENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
	09G183		B. WING _			
NAME OF P	ROVIDER OR SUPPLIER	1 000100				1/2008
MTS	NOTIDEN ON JOI TEEN		44	EET ADDRESS, CITY, STATE, ZIP CODE \$14-16 JAY STREET, NE /ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRÉCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOURD RE	(X5) COMPLETION DATE
W 114		age 3	W 114			
W 122	signed. 483.420 CLIENT F	PROTECTIONS	W 122			
	The facility must e	nsure that specific client		W122		•
	protections require	ements are met.		The Client Protections condition iss addressed as evidenced by the respo W148, W149, W153 and W154.	oucs have been pases for W127.	W 137,
	Based on observa review, the facility were implemented subjected to verba and mistreatment to ensure each clie appropriate size [S notify parents or gl [See W148]; the facility injurious of unknown reported to the adraccordance with S facility failed to pro-	is not rnet as evidenced by: tion, staff interview and record failed to ensure that systems to ensure clients were not I, physical, psychological abuse [See W127]; the facility failed ents clothing were of the tiee W137]; the facility failed to uardians of significant incidents acility's direct care staff failed to dent management policy [See failed to ensure that all wn source were immediately ministrator or to other officials in tate law [See W153]; and the evide evidence that all incidents f unknown origin had been tated [See W154]				
W 124	in the failure of the from actual and po- client's general sat	re systemic practices resulted facility to protect its clients stential harm and to ensure fety and well being.	W 124			
	Therefore the facili parent (if the client of the client's mediant)	nsure the rights of all clients. ity must inform each client, is a minor), or legal guardian, cal condition, developmental				

PRINTED: 11/19/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ICENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A, BUILDING B WING D9G183 10/31/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4414-16 JAY STREET, NE MTS WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 124 W 124 Continued From page 4 treatment, and of the right to refuse treatment. W124 Client #2's legal guardian (mother) did sign consents for the psychotropic drug regimen and the behavior support plan on 12-7-07 (See: attached copies)...12-2-08. This STANDARD is not met as evidenced by: MTS will utilize the new standard DDA forms to review Based on interview and record review, the facility and update Client #2's mother on the psychotropic drug failed to ensure the rights of each client and/or regimen and BSP...12-15-08. their legal quardian to be informed of the client's Thereafter, MTS will insure that a risks/henefits discussion medical condition, developmental and behavioral is held and consent is obtained for any changes in the status, attendant risks of treatment, and the right psychotropic drug regimen or the BSP...12-15-08. to refuse treatment, for the one of the two clients included in the sample. (Client #2) The finding includes: The facility failed to ensure that informed consent was obtained from Client #2 and/or her legal guardian prior to the administration of her psychotropic medications. Observation of the morning medication administration on October 29, 2008, at 8:48 AM revealed Client #2 was administered Prozac HCL 40 mg, Naitrexone Hydrochlonde 50 mg and Medestrol Acetate 10 ml. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the client's hand sucking behavior. During the entrance conference on October 294. 2008, an interview was conducted with the

Qualified Mental Retardation Professional (QMRP) and House Manager that revealed Client #2 did not have the capacity to give informed consent for the use of medications and

habilitation services. The QMRP's statement was verified on October 30, 2008, at 3:30 PM through review of Client #1's psychological assessment

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		09G183	B. WING		10/31/2008	
M T S	ROVIDER ÖR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP CODE 414-16 JAY STREET, NE VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
W 124	assessment, Clier independent decision day placements necessary to under decisions and their consent. She lack required to make or QMRP further reversably involvement making. Review of the clier additional interview 30, 2008, at 3:06 if that Client #2's trebenefits and poter her medications, a treatment, had be legally authorized 483.420(a)(5) PRORIGHTS The facility must earlier the facility were implemented subjected to verbal abuse and mistres abuse and mistres	on the sions concerning to the sions concerning her residential sions concerning her residential so the lacks the cognitive skills estand the implications of such refore cannot give her informed as the judgment and insight decisions independently." The saled the client had active at to assist her in decision on's medical record and with the QMRP on October of Mailed to provide evidence atment needs, including the stall side effects associated with and the right to refuse an explained to her and a representative. OTECTION OF CLIENTS Insure the rights of all clients. Sility must ensure that clients are shysical, verbal, sexual or se or punishment. Is not met as evidenced by: tions, staff interview and record falled to ensure that systems to ensure clients were not all, physical, and psychological atment for two of the four the facility. (Clients #2 and #3)	W 124	W127 a. The staff member that inap to force feed client #3 was the internal investigation fir	propriately after terminated bases adings12-2-01	npted d on
			 -	<u> </u>		[

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/19/2008 FORM APPROVED OMB NO: 0938-0391

CENTER	<u>IS FOR MEDICARE</u>	& MEDICAID SERVICES				OMR NO:	<u> </u>
STATEMENT	TEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G183	B. Wil	NG _		10/31	1/2008
NAME OF P	ROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 414-16 JAY STREET, NE	 	-
				<u> </u>	VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (XS) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (XS)		
W 127	breakfast observat #13 was observed harshly to Client #3 standing with her b and shoulder. At t arm was wrapped hand was under th position). DCS #1: Client #3, "Eat, I do do today." At 7:30 surveyor that Client At 7:31 AM, DCS # your mouth you kn #13 was then obsespoon into the client B. On October 29 was observed indecompleting her eg DCS #13 verbally several times but to observed to place mouthing). At 7:4: feed Client #2. Th by turning her hea AM, DCS #13 atte the client refused. observed putting t DCS #13 then pro Boost Plus in a sp At the time of the DCS #10 was pre- feeding Client #4. within hearing dist During the entrance	2008 at 7:18 AM during ions, Direct Care Staff (DCS) forcefully feeding and talking 3. DCS #13 was observed ody next to the client's head he same time, DCS #13's right over the client's head and her e client's chin (head lock 3 was overheard saying to on't have all day, I have a lot to AM, DCS #13 indicated to the at #3 was very difficult to feed. #13 said to Client #3, "Open ow you like the food." DCS erved forcefully sticking the nouth. 2008 at 7:15 AM, Client #2 ependently eating eggs. After gs, the client stopped eating. Prompted Client #2 to eat the client refused and was her hand into her mouth (hand 2 AM, DCS #13 attempted to see client was observed to refuse d away from the spoon. At 7:46 mpted to feed the client. Again At 7:48 AM, DCS #13 was he client's food down the drain. Vided the client with a bottle of		127	The two other staff members on duty a retrained on reporting and addressing a other serious reportable incident situat to duty 12-2-08. It should be noted that both the QMRP Manager observe meal implementation and both report that they have never se from the staff member terminated nor should also be noted that the two staff stated during their investigation intervever seen the terminated staff member member provide such inappropriate "a meals. The QMRP and Facility Manage observe meals for all shifts at minimus and will provide on the spot training of follow established protocols 12-15-11 in addition, the in-home staff orientation insure that mealtime protocols are to orientation 12-15-08. b. Client #2 has a mealtime protocols are to orientation 12-15-08. b. Client #2 has a mealtime protocols are to orientation 12-15-08. b. Client #2 has a mealtime protocols are to orientation 12-15-08. client #2 has a mealtime protocols are to orientation 12-15-08. b. Client #2 has a mealtime protocols are to orientation 12-15-08. client #2 has a mealtime protocols are to orientation 12-15-08. b. Client #2 has a mealtime protocols are to orientation 12-15-08. client #2 has a mealtime protocols are to orientation 12-15-08. client #2 has a mealtime protocols are to orientation 12-15-08. client #2 has a mealtime protocols are to orientation 12-15-08. client #2 has a mealtime protocols are to orientation 12-15-08. client #2 has a mealtime protocols are to orientation 12-15-08. client #2 began staff attempted to assist her refused and at 7:48am, 33 m started the meal, the staff member of the meal. At the surveyor, client #2 began staff attempted to assist her refused and at 7:48am, 33 m started the meal, the staff member of the meal or an ent for the meal or a	abuse/neglect a ions before returns before returns and the Facilian on a routine heen such behavious that neither or any other sissistance" during will continue monce weekly when staff fail to the will be moderated during to the that additionated during to the themselves and then returns and the return times after the meal of several times himites after the meal. The Cell indicated during to the themselves and the return add instructions sals to cat certains and instructions are infrequent that this is an infrequent	ty passis for It tuty or had tuff ing e to each o liffied he ress the efused hed by :15am, but was icnt #2 ed the ne s on in QMRP, ring the s not a

HRA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATÉ SURVEY COMPLETED		
	09G183		S. WING		10/31/2	วกกร
NAME OF P	ROVIDER OR SUPFLIER		44	EET ADDRESS, CITY, STATE, ZIP CODE 414-16 JAY STREET, NE /ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IÚ PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE 📗 l	(X5) COMPLETION DATE
W 127	Manager were info observation. At 4: surveyor's that DC administrative leavinvestigation. At 4:32 PM, the facilient's health and immediate jeopard facility implements immediate jeopard following: - the alleged abusileaving pending the the two additional alleged abuse were	age 7 ssional (QMRP) and House ormed of the surveyor's 00 PM, the QMRP informed the S #13 was placed on we pending the outcome of the cility was notified that the safety was at risk and an analy existed. At 5:00 PM, the ed a plan of correction to lift the ed. The plan consisted of the end outcome of an investigation; all staff that witnessed the elegated on administrative outcome of an investigation;	W 127	The mealtime protocol will be revised Staff will be retrained on the revised possible. The revised program will be implement to the revised program will be implement and that in refuse unwanted treatment and that in meal or portions of a meal. The protoc with respect for that right in mind but strategies that maximize the likelihood to consume her entire meal via positive respecting her right to choose (for exalter foods that she clearly dislikes)1	program by12-2 nted by12-27-0 dividual's right to cludes an occasion col will be modifie will provide d of getting client re reinforcement a umple, by not serv	8. nailed
W 148	31, 2008 on abuse reporting, mealtim Behavior Support [It should be noted onsite until the factoremove the immed 483.420(c)(6) COI CLIENTS, PAREN The facility must reparents or guardia changes in the clients.	I that the surveyor remained illity put systems in place to diate jeopardy.] MMUNICATION WITH ITS & notify promptly the client's an of any significant incidents, or ent's condition including, but not illness, accident, death, abuse,	W 148			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
09G163		09G163	8. WING		10/31/2008	
NAME OF P	ROVIDER OR SUPPLIER		44	EET ADDRESS, CITY, STATE, ZIP CODE 114-16 JAY STREET, NE (ASHINGTON, DC 20019	10/0 //2000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
W 148	Continued From pa	age 8	W 148			
	Based on interview failed to notify pare incidents for one of facility. (Client #5) The finding include On October 29, 20 entrance conferent Retardation Profest Client #5 had active			W148 The family of Client #5 was notified al cited here and in fact did visit her in th MTS staff failed to indicate the notifier report. The QMRP will review all incit they are submitted to insure that all appropriate a second cross check before sure. Staff was retrained on appropriate incitepart development on10-30-08. The issue will be addressed at minimum.	e hospital thereafter, ation on the incident dent reports before propriate d. The IMC will abmission 12-15-	
'	investigative report beginning at 10:20 failed to notify Clie the following incide	ts on October 29, 2008 OAM, revealed that the facility and #5's family immediately of ent: staff discovered swelling on the		monthly staff meetings 12-15-08.		
W 149	however, failed to client's family had aforementioned in	of the facility's incident report provide evidence that the been notified of the cident. AFF TREATMENT OF	W 149		Ţ.	
	policies and proce	levelop and implement written dures that prohibit lect or abuse of the client.	i L			
	Based on interview facility's direct can incident managem	is not met as evidenced by: ws and record review, the e staff failed to implement it's nent policy for two of four clients ility. (Clients #2 and #3)		W149 Staff was retrained on incident report will be trained at least once per quarte staff meetings12-15-08.		

		AND HUMAN SERVICES				PRINTED: 11/19/2008 FORM APPROVED OMB NO. 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
-		09G183	B. WI	NG_		10/	31/2008
M T S	ROVIDER OR SUPPLIER		· · · · · ·	4	REET ADDRESS, CITY, STATE, ZIP CODE 1414-16 JAY STREET, NE WASHINGTON, DC 20019		31/2000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST 3E PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF	·IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULDEE	(X5) COMPLETION DATE
W 149	Continued From pa	ge 9	W	149		<u> </u>	
	The finding include:	s:					
	at 7:18 AM during to Care Staff (DCS) # feeding and talking AM, DCS #13 verba several times but the observed to place himouthing). During attempted to feed Cobserved to refused from the spoon. At to feed the client. A 7:48 AM, DCS #13 client's food down the DCS #10 was present to the spoon of the af DCS #10 was present to the spoon.	orementioned observations, ent at the dining room table DCS #5 was in the facility and					
	2008 at 9:20 AM, th Retardation Profess Manager were infor- observation. At 4:00 surveyor's that DCS	sional (QMRP) and House med of the surveyor's DPM, the QMRP informed the				·	
	Qualified Mental Re (QMRP) on October ascertain if the facili management policy policy entitled "Resir	tanducted with the facility's tardation Professional 29, 2008 at 9:30 AM, to ty had a written incident. The QMRP provided a dent Protection" with a uary 30, 2008. Review of that					

	ATÉMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI		LE CONSTRUCTION	COMPLETED	
		09G183	B. WING			10/31/2008	
NAME OF PE	ROVIDER OR SUPPLIER			44	EET ADDRESS, CITY, STATE. ZIP CODE 114-16 JAY STREET, NE VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC		PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
W 149	requirements pertamistreatment report the incider - follow the instruct and - complete an incident of the complete and the co	29, 2008 included the following aining to abuse, neglect or rting: Int to a supervisor immediately; Itions given by the supervisor;	W	149			
VV 150	483.420(d)(1)(i) S CLIENTS Staff of the facility	TAFF TREATMENT OF must not use physical, verbal, ogical abuse or punishment.	W	150	W150 Scie: respuisses fo	or W12 7.	
	Based on observative review, the facility were implemented from physical, ver	is not met as evidenced by: ations, staff interview and record failed to ensure that systems d to ensure clients were free that and psychological abuse for ents residing in the facility. 3)		٠	·		
	The finding includ	les:					
	7:18 AM during b Care Staff (DCS) feeding and talkin was also observe several times but was observed to	e W127] On October 29, 2008 at reakfast observations, Direct #13 was observed forcefully ng harshly to Client #3. DCS #13 ad attempting to feed Client #2 the client refused. The client place her hand into her mouth After DCS #13's last attempt to	3 ,				

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		09G183	B. WING			10/31/2008	
NAME OF F	PROVIDER OR SUPPLIER			4414-1	ADDRESS, CITY, STATE, ZIP CODE 6 JAY STREET, NE HINGTON, DC 20019	1 1010	72000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDAF	(X5) COMPLETION DATE
W 150	feed Client #2 at 7 observed to discar down the drain. At the time of the a DCS #10 was presideding Client #4. within hearing distribution of the action of the action. At 4:32 PM, the faction of the action of t	aforementioned observations, sent at the dining room table DCS #5 was in the facility and ance of the incident. The conference on October 29, the Qualified Mental assional (QMRP) and House formed of the surveyor the QMRP informed the S #13 was placed on the pending the outcome of the cility was notified that the safety was at risk and an analy existed. At 5:00 PM, the da plan of correction to lift the lift. The plan consisted of the conference of an investigation; all staff that witnessed the explaced on administrative outcome of an investigation; and client #2's	W	150			

NAME OF PROVIDER OR SUPPLIER MT S B. WING STREET ADDRESS, CITY. STATE, ZIP CODE 4414-16 JAY STREET, NE	ECTION ROULD BE	1/2008
MITS 4414-16 JAY STREET, NE	ECTION ROULD BE	
WASHINGTON, DC 20019	OULD BE	(X5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRI PREFIX (EACH DEFICIENCY MUST 3E PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD FROM THE APPLICATION OF CROSS-REFERENCED TO THE APPLICATION OF CORRECTIVE ACTION SHOULD NOT THE APPLICATION OF CORRECTIVE ACTION OF CORRECTIVE		(X5) COMPLETION DATE
W 150 Continued From page 12 onsite until the facility put systems in place to remove the immediate jeopardy.] W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all injurious of unknown source were immediately reported to the administrator or to other officials in accordance with State law, for two of the four clients included in the sample. (Clients #1 and #5) The findings include: 1. Review of the facility's incident reports on October 29, 2008, beginning at 10:20 AM revealed an incident involving Client #5 giaw and face. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on October 29, 2008, at 11:00 AM to ascertain information regarding the facility's incident management system. According to the QMRP, all incidents were to be reported to the administrator. Further review of the incident report, however, revealed that there was no documented evidence that indicated the administrator had been notified. At	origin. Client #5 origin. Client #5 origin. Client #5 dic flare ups of fully explain the attached late 2-2-08. Iso not of unknown the spitalization as 1 to get out of the 10 fully documnoles mention the Sec: attached late. 12-2-08. of Nursing (DO dithe QMRP the diress such issamples up the spitalization the spitaliz	(See: this a this type is in the client ed. cut this he bruise ble entry ON) will at their hes

	F CORRECTION	IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ittiple construction Ding	(X3) DATE SI COMPLE	
		· 09G183	B. WING	·	10/3	. , 1/2008
M T S	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 20 4414-16 JAY STREET, NE WASHINGTON, DC 20019		112000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 153	evidence that ensuimmediately notified origin. 2. Review of Clier October 29, 2008 arevealed the follow was not reported to a nursing progrestaff discovered a below the knee. Freview revealed not immediately and the staff discovered and the staf	age 13 ured the administrator was ad of the incident of unknown at #1's medical record on at approximately 2:00 PM, ring injury of unknown origin to the Administrator. According less note dated June 19, 2008, bruise on Client #1's left foot urther interview and record to evidence that the injury of reported to the Administrator.	W 1	53		
W 154	as required. 483.420(d)(3) STA CLIENTS The facility must h	FF TREATMENT OF ave evidence that all alleged bughly investigated.	W 18	W154 Sec: responses for Vi	VIS3 shove.	
<u>-</u>	Based on interview failed to provide ex involving injuries o thoroughly investig	is not met as evidenced by: v and record review, the facility vidence that all incidents f unknown origin had been lated, for two of the five clients lity. (Clients #1 and #5)	·			
	The findings includ	le:		'		
	Retardation Profes the facility's incider	facility's Qualified Mental scional (QMRP) and review of nt reports on October 29 2008 AM revealed the following n origin:				,
	on Client #1's left f	08, staff discovered a bruise foot below the knee. Continued by's incidents failed to provide				

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Nov. 21 2008 02:16PM P 5

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		09G183	B. WING		10/3	1/2008
NAME OF PI	RÓVIDER OR SUPPLIEI		441	ET AODRESS, CITY, STATE, ZIP 14-16 JAY STREET, NE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(Bach Deficien	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ÓN SHOULD BE HE APPROPRIATE	(35) COMPLETION DATE
W 154	b. On June 9, 20 Client #5's jaw an no evidence the 483.430(a) QUA RETARDATION Each client's actintegrated, coord	incident had been Investigated. 108, staff discovered swelling of hid face. Additionally, there was incident had been investigated.	W 154 W 159			
	Based on observeriew, the facility active treatment coordinated and Mental Retardat three of the four (Clients #1, #2, The findings inclient received continues. [See 12]	clude: QMRP failed to ensure each continuous active treatment		W159 The issues cited under W evidenced by the respons		
W 193	[See W252] 483.430(e)(3) S Staff must be a techniques nec	TAFF TRAINING PROGRAM ble to demonstrate the skills and essary to administer interventions inappropriate behavior of clients.	W 193			
	This STANDAF	RD is not met as evidenced by:				not Page 15 of

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTEL): 11/21/2008 APPROVED
SIATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	OMB NO (X3) DATE (COMPL). 0938-0391 Burvey
		09G18 3	B. WING_			
NAME OF F	ROVIDER OR SUPPLIER		╼┺┈╌		10/:	31/2008
MTS			1 9	REET ADDRESS, CITY, STATE, ZIP COU M14-16 JAY STREET, NE NASHINGTON, DC 20019	PE -	
(X4) ID PREFIX TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		COMPLETION DATE
,	Based on observativerification, the facilidemonstrate the ski to implement each ((BSP)), for one of the (Client #1) The finding includes On October 29, 200 observed eating egg breakfast observation intens/gloves on he client was observed mouth (hand mouthly intervention. At 7:53 gloves and began storage staff asked the 7:59 AM, the direct oputting the clients mouther clients with the direct oputting the client sucks on hitme. Record review on Organization of the client sucks on hitme. Record review on Organization of the client sucks on hitme. Record review on Organization of the client sucks on hitme. At any time that Clients activity with one to omaterials or gently beclient for 10-15 minutely taking her hand or the client for 10-15 minutely taking her hand of the client for 10-15 minutely taking her h	ons, staff interview and record lity's staff failed to lits and techniques necessary client's Behavior Support Plan a two clients in the sample. 8 at 7:10 AM, Client #1 was as for preakfast. During the lons, the client had er hands. At 7:25 AM, the placing her hands into her long. There was no staff a AM, the client took off the licking her fingers. The direct client to, "please stop." At lare staff was observed littens/gloves on her hands, rect care staff indicated that her hands and fingers, all the	W 193	DEFICIENCY	stegies for client will separately a a conducted by staff on the spo grams or protoc a portion of the	it #2,10- ubscrve cach shift it when cols are

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Nov. 21 2008 02:16PM P 7

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSI	TRUCTION	C	X3) DATE SU	
			A. BUII	.DING		_	COMPLE	TED
		09G183	B. WIN	ß		1	45/5/	
MTS	ROVIDER OR SUPPLIER			4414-16 JAY	ESS, CITY, STATE, ZIP (Y SYRRET, NE TON, DC 20019	CODE	10/3	1/2008
(X4) ED PREFIX TAG	I (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL &C IDENTIFYING INFORMATION)	ID PREFI TAG	X (E/-	PROVIDER'S PLAN OF C NCH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY	ON SHOUL HE APPRO	N DE	(XS) COMPLETION DATE
W 193	- If she continues a mouthing for 30 mi hands and direct he	nd is persistent in hand nutes place the gloves on her er to an activity with physical we the gloves after 15 minutes	W 1	93		<u>-</u>		
-	observed being imposserved repeated with the facility's Quarter Professional (QMR 9:20 AM confirmed	d intervention were not blemented when Client #2 was by hand mouthing. Interview ualified Mental Retardation P) on October 29, 2008 at direct care staff didn't enting the proactive strategies 2 s BSP.						
W 249	30, 2008 at approx all staff signed and #2's BSP. There w was successful. 483.440(d)(1) PRO	training records on October imately 1:30 PM revealed that received training on Client ras no evidence that training of GRAM IMPLEMENTATION redisciplinary team has	W 2	49		·		
·	formulated a client' each client must re treatment program interventions and s and frequency to s	s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the Individual program						
	Based on interview failed to ensure ea active treatment se	is not met as evidenced by: and record review, the facility ch client received continuous ervices, for one of the two the sample. (Client #1)			·	,		
CODM CMC o	S67/07-09\ Desvious Version	Charleta Same (M-MOVI)		English ID: 605				<u> </u>

FROM :MTS CORP. 11/21/2008 15:04 FAX 2024429430

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		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED; FORM / OMB NO.	11/21/2008 APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULT A. BUILDIN	PLE CONSTRUCTION G	(XZ) DATE SU COMPLET	RVEY
		09 G183	B. WING_		10/34	1/2008
NAME OF P	ROVIDER OR SUPPLIER		870	REET ADDRESS. CITY. STATE, ZIP CODE	19/3	1/2000
.MT9			4	414-16 JAY STREET, NE VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX PAT	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 249	Continued From pa	ige 17	W 249			
	The finding include	·	*****	W249	,	
	2008 at 10:00 AM r Individual Support I Interview with the C Professional (QMR 10:30 AM and furth revealed that at the Interdisciplinary Te following program of a. [the client], will p exercises in 10/10 formation to prepar consecutive month b. [the client], will p exercises in 10/10 formation to prepar	perform lingual strengthening trials to improve bolus of for swallowing over three s; and perform labial strengthening trials to improve bolus or for swallowing over three		The protocol needed for the proper is lingual strengthening and labial strengthening and labial strengthen to been developed by the speech pale completed by 12-4-08. Staff will be trained on the implement by 12-8-08. The programs will be implemented to The programs will be implemented to line but was having difficulty getting to provide the needed protocols and elements. In the future, the QMRP will of the Executive Director to move su timelier manner 12-20-08.	ightening exention of the program of the speech part of the speech part of the program of the pr	cises had y will be es ams on thologist
W 252	client's records on approximately 11:0 that the aforement been developed, in 483.440(e)(1) PROData relative to accepted in client is	S. CMRP and raview of the October 30, 2008 at 10 AM, there was no evidence ioned program objectives had litiated or implemented. CGRAM DOCUMENTATION complishment of the criteria andividual program plan e documented in measurable	W 252			-

This STANDARD is not met as evidenced by: Based on observations interview, and record review, the facility failed to ensure that data was DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & ME

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CTATOR	TON WEDICARE	A MEDICAID SERVICES			FORM	APPROVED
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(XS) WITH	TIPLE CONSTRUCTION	OMB NO	<u>), 0938-039</u> 1
ł		IDENTIFICATION NUMBER	A BUILDI		(X3) DATE S	BURVEY
					002,0	E) CV
NAME OF	PROVIDER OR SUPPLIER	09@183	B. WING			
1 10 4015 (4)	LYCAIDER ON SUPPLIER		ST	PEET ADDRESS OF A	10/3	31/2008
MTS				REET ADDRESS, CITY, STATE ZIP CO 4414-18 JAY STREET, NE)DE	
-			1	WASHINGTON, DC 20019		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID.			
TAG	REGULATORY OR LE	SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION		(XS)
	<u> </u>		TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
W 252	Continued From pag	ne 18				<u> </u>
	collected in the form	and required frequency, for	W 252			
	one of the two citems	is in the sample, (Client #2)	ĺ	İ		1 1
		is in the sample, (Client #2)		W252		'.
	The finding includes	:				
				Staff indeed failed to collect the on the survey date but have been	Walking dat - c	
	On October 29, 200	8 from 4:35 PM until 4:41 PM,		on the survey date but have been was retrained to insure future con	consistent other	ctions #2
	LAMON MOS ORRGINSON	1921211071 (Clicat-40		In addition the Charge	12-2.	18.
	Care staff indicated to	y. Interview with the direct		date routinely to inch.	ity Manager will	check the
_	had an unsteady sei	hat the client can walk but L. Review of the client		collection12-2-08.	cy in the data	
•	Individual Program F	Plan (IPP) dated June 24,				,
	SAME ALL COMPRESSES	- /UNIX Of OBBROSEMENTAL CALOR !				
•	I TIM I GYGGIGU AN DOM	COVO Which About 766 (
	arending assistance	(INA client) will ambulate the				1
	I I A COMPOCUUVE INIUM	IES IVE dave her whole for 40 !				
	LACINGCOUNTE TUDDITUS	KRYIMA Of the date chart	}		}	
	Un Uctober 30, 2008	failed to reflect the				
	ambulation on Octob	er 29, 2008.				
	There was no eviden	ca that the data had been				
	collected in accordan	ice with the IPP for the client,				
1	WILLIAM AS DECESSED	/ IOF & functional accompany				1
	or me cuantra blodtes	36.			1	
W 257	483.440(f)(1)(iii) PRO	OGRAM MONITORING &	W 257		!	1
	CHANGE		VV 257			
į	Th-1 21.	İ	l		ì	1
	I ne individual progra	m plan must be reviewed at				İ
İ	least by the qualified	mental retardation	1			
	high bot jimited to ""	sed as necessary, including,				
1	failing to progress two	etions in which the client is ward identified objectives	Í			• 1
1	after reasonable effor	ds have been made	ł		ĺ	i i
'			ļ	•		
}					1	-
	This STANDARD is	not met as evidenced by:	}		ì	•
	Based on Interview a	nd record review the			l	
	Qualified Mental Reta	ardation Professional				ł
j	CUMRY) failed to ens	ure each clients Individual	1			
	(IPP) v 	vas revised after the client			1	
			- 1			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DE AND PLAN OF CORI	FICIENCIES RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
·		09G18a	B. WING_			
NAME OF PROVIDE	er or supplier		4	REET ADDRESS, CITY, STATE, ZIP CODE 414-16 JAY STREET, NE VASHINGTON, DC 20019	10/3	1/2008
(X4) ID PREFIX (TAG R	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIDEFICIENCY)	III fa pe	(XS) COMPLETION DATE
failed object the s The 1 The 1 tooth reflect docu 30, 2 the for teeth assis Reviel QMR alway assis There of the service of th	ctives, for one ample. (Clien	gress with the identified of the two clients included in it #2) s: o revise Client #2's rem as performance measures progress. The client's I IPP was reviewed on October PM. The client's IPP reflected tive, "[the client] will brush her ficiency given physical onsecutive occasions." collection sheets and the test on October 30, 2008 at that the client had been hand over hand" assistance 08. Interview with the facility's revealed that the client had at the "hand over hand" the regards to this program. The that the toothbrushing revised as necessary. ROGRAM MONITORING & Duild insure that these programs with the written informed int, parents (if the client is a	W 263	W257 Client #2 will not improve beyond the assistance level for the tooth brushing RN and Facility Manager agree with a brushing will be discontinued as a for done as a structured activity. A protoc to instruct staff on properly supporting brushing task 12-20-08.	task. The Qi his assessme mal objective	MRP, nt Tooth and bc

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT AND PLAN Q	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	1.	LDING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	RVEY
		09G183	B. Wi	₩G		10/31	1 /200 8 .
NAME OF P	ROVIDER OR SUPPLIER			STO.	EET ADDRESS, CITY, STATE, ZIP CODE	1 1013	72490
MTS				44	MASHINGTON, DC 20019		,
(XA) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	LILDBE	(XS) COMPLETION CATE
W 263	Continued From p	age 20		263			
	,	d in the sample, (Client #2)	•				
	The finding includ	es:					
	Observation of the	e morning medication					
	administration on	October 29, 2008 at 8:48 AM			W263		
•		received medications including		ļ			
	Prozac and Natire	exone. Interview with the during the medication			As mentioned earlier, signed consen- risks/benefits discussion on 12-7-07	t was obtaine	। शिक्त इ
• .		ealed the aforementioned			psychotropic drag regimen for client	L #2 12-2-01	l
		sed to address the clients			MTS will update the consent docum	entation ratios	the
	behavior of hand	mouthing.			shandard DDA forms for both ASPs regimens, 12-20-08.	and psychotro	bịc quiề ,
	 Interview with the	Qualified Mental Retardation			In addition, consent will be obtained	for any chara	as in the
		P) on October 29, 2008 at 9:20			psychotropic drug regimen or the 135	il, ettaregies"	. 12-20-
	AM revealed that	Client #2 did not have the			· CAL		
		oformed consent for the use of and habilitation services. The					
		of was verified on October 30.					
	2008 at approxim	ately 11:00 AM through review					
		chological assessment dated				•	
		according to the assessment, of evidence the capacity to make				•	
		sions on her behalf regarding					:
}	her habilitation pl	anning, placement, treatment,			\		-
		dical matters due to profound			\		}
		n. She can not execute a attorney." Continued interview					
· ·	with the QMRP of	n October 30, 2008, further	·				
	revealed that Clie	ent #2 had very involved family					
	Involvement.						1
ļ	Further review of	Client #2's record on October					
	30, 2008 at 11:00	DAM revealed that the client, in	ļ				
1	addition to taking	psychotropic medications, also	'				
1		Support Plan dated June 13, her behavior of hand mouthing.					
		survey however, the facility					

PRINTED: 11/21/2008
FORM APPROVED
OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION
A BUILDING

(X3) DATE SURVEY
COMPLETED

AND PLAN	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G183	(XZ) M A. BUI B. W()	LDIN		(X3) DATE S COMPL	
NAME OF F	PROVIDER OR SUPPLIER	V3G163				10/3	1/2008
MTS	· · · · · · · · · · · · · · · · · · ·			4	REET ADDRESS, CITY. STATE, ZIP CODE 414-16 JAY STREET, NE VASHINGTON, DC 20019		
(XA) ID PREFIX TAG	REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUSY BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IDUI o be	COMPLETION DAYE
W 263	falled to provide evolutained for the us medication and Bewere designed/combehaviors. [Cross 483.460(k)(2) DRU The system for druthat all drugs, incluself-administered, incluself-administered, incluself-administered, incluself-administered, incluself-administered, incluself-administered, incluself-administered, included the four clients of the	idence that consent was e of the psychotropic havior Support Plan (BSP) that ducted to reduce Client #2's serefer to W124] IG ADMINISTRATION g administration must assure ding those that are are administered without error. Is not met as evidenced by: ion, and record review, the sure that each client received lications without error for four esiding in the facility. (Clients	W		1. The masal spray was given nurse who omitted the me medication pass was retra Client #4 was observed as instructe effects of the delay in receiving the The QMRP, Facility Manager and I medication passes as implemented inurse to insure that she routinely poprescribed and documents her folloconsistently 12-20-08. The RN will review the MTS mediwith the medication nurse once agathe guide is available for review row. 2. The nurse was delayed at failed to notify the RN or running late. The clients observed and showed not their medications slightly window prescribed by the The medication warse was retrained pass policies 12-2-08.	dication during ined on 10-29-d and showed inedication RN will observe by the aforement of the property of the aforement of the property o	g her -08, no ill 12-2-08, re antioned attions as IARs guideline aire that 0-08, or eceiving a two hour . 12-2-08.

RN called the Primary Care Physician (PCP) to inform her of the medication error. The PCP

FAX NO. :2022448048

Nov. 21 2008 02:17PM P 13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G1 8 3	B. WING_		4024	
M T S	ROVIDER OR SUPPLIER		. 44	EET ADDRESS, CITY, STATE, ZIP CODE 114-16 LAY STREET, NE /ASHINGTON, DC 20019	10/31/	12008
(X4) ID PREFIX TAG	! (EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX YAG	PROVIDER'S PLAN OF GORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	LILDRE	COMPLETION CATE
W 369	and administer the to the RN, she adm at approximately 1. 2. On October 29, medication nurse a administer Client # medications. Ravidated October 1, 2 medications are to The first dose of m Client #3 at 8:29 Al administered to Climedication was no of one hour before prescribed time. On October 29, 20 the RN was inform	o go to Client #4's day program client's medication. According ninistered Client #4's Nasonex	W 369			•
W 392	Care Physician (Pomedication error, instructed the RN (and #4 affect 463.460(m)(3) DR Drugs and blologic designated for a primmediately removed medication supply	CP) to inform her of the According to the RN, the PCP to monitor Client #1, #2, #3,	W 3 92	W392 M1'S' medication disposal policy n		
	Based on observa verification, the fac remove discontinu	is not met as evidenced by: tion, staff interview and record ality failed to immediately and medication from the clients in supply, for one of the two		climinate the instruction to flush su pharmacy does not take back contro policy will be revised to instruct no sprinkle such medications and disc that form. This plus properly docur be the MTS practice going forward	olled medications of the medical of them in the medical them in the medical the set	ons, MTS ad trash in

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/21/2008 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/BUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 09G183 B. WING NAME OF PROVIDER OR SUPPLIER 10/31/2008 STREET ADDRESS, CITY, STATE, ZIP CODE MTS 4414-16 JAY STREET, NE WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (AB) COMPLETION TAG DATE W 392 Continued From page 23 W 392 clients included in the sample. (Client#1) The finding includes: Inspection of the medication supply cabinet on October 29, 2008 at 9:10 AM, revealed a medication package of Klonopin 0.5 mg, 30 tablets for Client #1. Interview with the medication nurse at 9:15 AM indicated that the medication was discontinued around August 2008. Further interview indicated that the medication should have been returned to the pharmacy. Record verification on October 29, 2008 at 10:15 AM revealed a physician order dated August 24, 2008, to "Stop Klonopin," However, the medication was still stored in the medication cabinet as of October 29, 2006.

FORM CMS-2567(02-99) Provious Versions Obsolote

Event ID: MOY011

Facility ID; 09G183

If continuation sheet Page 24 of 24

PRINTED: 11/19/2008 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIP A. BUILDING B. WING		(X3) DATE SU COMPLE —	
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1 000	29, 2008 through of fundamental surve however due to co and Active Treatmin those areas. A random sample from a residential one male with mel disabilities. The sobservations in the program, interview including unusual. On October 29, 20 that staff's conducting breakfast pureat to their hear facility's Qualified Professional (QM notified that an imsurveyor remaine addressed the immimplementing the identified concern from further poter. - the alleged abuse we leave pending the and. - all remaining staff.	was conducted from October 31, 2008. They process was initiated process in Client Protection of two residents was population of three fental retardation and ourvey findings were be group home and at wis and a review of rediction of the fental retardation and at wis and a review of rediction and a review of rediction and protect towards Residents posed an immediate a lith and safety. At 4:3 Mental Retardation RP) and Program Direction and protect the resident protect the resident protect the resident protect the resident protect the resident protect the resident protect the resident protect the resident protect the resident protect the resident protect the resident protect the resident protect the resident protect the resident protec	the ed ections extended sections extended sections extended sections extended sections and extended on one day cords, was made #2 and #3 and serious \$2 PM, the rector were isted. The illity viate the eldent's ministrative estigation; d the strative stigation; by October				
	reporting, mealting	ne protocols, and Clie	ent #2's				
iealth Reg	ulation Administration				TITLE		(X8) DATE

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0181	(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION	(X3) DATE 8 COMPL	
AME OF P	ROVIDER OR SUPPLIER	STREE	ADDRESS, CITY,	STATE, ZIP CODE		
TS		4414- WASH	16 JAY STREET IINGTON, DC 2	Г, NE 10019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST 3E PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
I 000	made that the facili	_				
1 043	Modified diets shale (c) Reviewed at lease This Statute is not Based on record record record record record reviewed at lease that the modeen reviewed at lease the modeen reviewed at lease that the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen reviewed at lease the modeen	est quarterly by a dietitian. I met as evidenced by: eview, the GHMRP failed to odified diet for residents had east quarterly by the consult	I 043		,	
	The findings included the findings included	de: dent #1's nutritional July 18, 2008 on October 2 ately 2:15 PM revealed that t cribed a regular pureed diet	he	Chapter 35 3502.20		
	failed to show evid Nutritionist had rev quarterly basis. R facility's ISP meeti 2008 at 9:15 AM re quarterly review w 2008. At the time	and high fiber. Further review lence that the facility's viewed Resident #1's diet on ecord verification of the ng schedule on October 31, evealed that the client's first as scheduled for October 18 of the survey, the GHMRP attrition quarterly review.	а	The nutrition quarterly has f The QMRP will audit all dis that all outstanding tasks are manner12-20-08.	Cipline notes monthly	tes Services
	was observed eati	, 2008 at 7:15 AM, Resident ing pureed eggs for breakfas also observed drinking a bot	st.			

MOY011

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE HFD03-0181	A. BUILDING B, WING		(X3) DATE SURVEY COMPLETED - 10/31/2008	
NAME OF PR	4414-16 J					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION	ILL PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
	assessment dated 2008 at approximathe resident was p double portion high can of Boost Plus, failed to show evid Nutritionist had reviguarterly basis. R facility's ISP meeti 2008 at 9:15 AM in quarterly review w 24, 2008. At the tifailed to have a nutritionist shall be ensure that each in prescribed a modinutrition according Habilitation Plan.	view of Resident #2's nu June 19, 2008 on Octo litely 10:00 AM revealed rescribed a regular pure of fiber diet with snacks at twice per day. Further lence that the facility's viewed Resident #2's die ecord verification of the ng schedule on October evealed that the client's as scheduled for Septerme of the survey, the Gatrition quarterly review. ERVICE / DINING AREA sultation by a dietitian or econducted at least quaresident who has been fied diet receives adequate to his or her Individual	ber 30, that eed and one review et on a r 31, first mber HMRP			
,	Based on observer verification, the G consulting dietitian reviews for reside	ot met as evidenced by: ations, staff interview an HMRP failed to ensure to n conducted at least qua nts on modified diets fo in the sample. (Reside	that the arterly r two of			
	The findings inclu	de:		. 3502.16		
	assessment date 2008 at approxim resident was pres	ident #1's nutritional d July 18, 2008 on Octo ately 2:15 PM revealed cribed a regular pureed and high fiber. Further	that the diet	See responses for 3502.2	C above	

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: <u> </u>	egulation Administra	ation				1- Q-CJV(AFFROVED
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI HFD03-0181		A. BUILDING	PLE CONSTRUCTION	(X3) DATE S COMPLI	
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1 058	failed to show evidentifications had reviguarterly basis. 2. On October 29, was observed eath. The resident was a of Boost Plus. Revassessment dated 2008 at approximathe resident was produble portion high can of Boost Plus, failed to show evid Nutritionist had reviguarterly basis. 3507.4(e) POLICIE The manual shall in procedures for at 100 (e) Personnel, which qualifications, staff staff development, This Statute is not Based on review of Mentally Retarded ensure that their Princluded a personnel descriptions and quartios, training and inventories. The finding includes	ence that the facility's lewed Resident #1's 2008 at 7:15 AM, Reng pureed eggs for balso observed drinking of Resident #2's June 19, 2008 on Octely 10:00 AM reveal rescribed a regular partition of the facility's riewed Resident #2's ES AND PROCEDUF incorporate policies a east the following: ch covers job descriptives descriptives and procedure in the facility's riewed Resident #2's east the following: the covers is the descriptives of the covers is descriptives and procedure in the facility's records the Group Persons (GHMRP) is colicies and Procedure in the facility that address unalifications, staff/resident, as the following is staff development, as the facility is the facility of the facility in the facility is the facility of the facility of the facility is the facility of the fac	esident #2 reakfast. g a bottle nutritional ctober 30, led that ureed ks and one er review diet on a RES and otions and aing and y: Home for failed to res' Manual sed job sident and health	I 167	Existing MTS policies address qualifications, stafffresident raccatificates (see: attachments). However, MTS is in the processonnel policy manual that at 1:08.	cros, training and h 12-2-08,	*
Health Regu	October 30, 2008,	failed to provide evident addressed job de	dence of a				

Health Regulation Administration

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	TEMENT OF DEFIGIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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	and staff develop 3508.5(b) ADMIN Each GHMRP shithat shows the foil (b) The personner components; This Statute is not be an organized personnel in chain the finding included an October 30, 2 the organization personnel in chain the finding in chain the finding included and the finding included	s, staff/resident ratios, ment, health inventorion with the support all have an organization of the program of the program content as evidenced by review, the GHMRP fation chart the showed rate of the program content failed to identify the program cont	es. Ton chart gram by: ailed to the mponents. e records aled that the mponents.	! 185		(b) and 3508(c)	rts12-
	This Statute is r Based on review manual and requ GHMRP failed to	not met as evidenced a v of the policy and pro- uest of management s o provide an organizat ories and numbers of s staff.	cedures staff, the sional chart				
Health Reg	gulation Administration			GROB	MOY011	If appairs	alien sheet 5 of 1

PRINTED: 11/19/2008 FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING HFD03-0181 10/31/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE MTS WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE TAG TAG DATE DEFICIENCY) J 186 Continued From page 5 1186 Review of the GHMRP's administrative records on October 30, 2008 at 1:00 PM, revealed that the organization chart failed to list the categories and numbers of supportive and direct care staff. 1203 3509.3 PERSONNEL POLICIES 1203 Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. 3509.3 This Statute is not met as evidenced by: Job description updates have been completed for the staff Based on record review, the GHMRP failed to cited (sec: attached copies),...12-2-08. have on file for review current job descriptions for The Facility Manager perform quarterly audits in order to all employees. track due dates and insure routine updates..., 12-20-08. The findings include: Review of the personnel files conducted on October 31, 2008 at approximately 11:00 AM. revealed the GHMRP failed to provide evidence that the facility discussed the contents of job description with staff. It should be noted that the present recorded did not include a job description for Staff #2, #6, #11, and #12. 1224 3510.5(a) STAFF TRAINING 1224 Each training program shall include, but not be limited to, the following: (a) Overview of mental retardation including, but 3510.5(a) soul (b) not limited to, definition, causes of mental retardation, associated health implications, and

Health Regulation Administration

living skills;

frequently used medications, the history of care

of individuals with mental retardation, and daily

STATE FORM

by...12-20-08.

Introduction to mental retardation and Human

Development are covered in the MTS staff orientation but

the QMRP will conduct a training session for all staff

Ø 028

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O	FR I	!) MULTIPI BUILDING	E CONSTRUCTION	(X3) DATE S COMPL			
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1 224	Based on record r	age 6 of met as evidenced by: review, the GHMRP falk overview of mental reta		24					
-	2008, revealed th	es; ning records on Ocotbe at the GHMRP failed to w of mental retardation.	provide						
1 225	3510.5(b) STAFF Each training proplimited to, the follow	gram shall include, but r	not be	25	·				
. '	(birth to death); This Statute is no Based on record	opment through the life of the tas evidenced by: review, the GHMRP fail as provided to each sta- revelopment.	led to						
	The finding include Review of the tra 2008 revealed the training in Human	ining records on Octobe at the GHMRP failed to	er 30, provide						
1 23	limited to, the following	ogram shall include, but lowing: e residents in the maints	not be	232	3510.5(i) Dental (oral health and hygien attached copy of signature she by12-20-08. The QMRP will develop a Jan schedule outlining all required implementation timelines12 The schedule will be modified	er) but will be don many through June I trainings and the 2-30-08.	ie again : 2009 ir		

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NAME OF PROMITS (X4) ID PREFIX TAG 1 232 (OF DEFICIENCIES F CORRECTION ROVIDER OR SUPPLIER SUMMARY STA	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	STREET ADD	A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE S		
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M T S (X4) ID PREFIX TAG I 232 (EEEE EEEE EEEE EEEE EEEE EEEE EEEE	SUMMARY STA			DECC CITY	TARRESP CITY OF THE STATE OF TH			
I 232 (EEE STEELS STEEL	SUMMARY STA	4414-16 WASHIN		ET ADDRESS, CITY, STATE, ZIP CODE -16 JAY STREET, NE HINGTON, DC 20019				
1 291 3 E S	REGULATORY OR L	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	un l	ID PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
E S	ensure training was ara of oral and hea The finding include Review of the traini	view, the GHMRP fails provided to each start the hygiene. s; ng records on Octobe the GHMRP failed to	off in the	1 232			2	
T T R	signed by each indi This Statute is not Based on interview GHMRP failed to er were kept current, of individual that made residents in the san The findingd include The facility's Regist Residents #1 and # a. Interview with the on October 29, 2006 revealed that she (Finursing examination	e kept current, dated, vidual who makes an met as evidenced by: and record review, the sure each residents related and signed by each each entry, for two of the ple. (Residents #1 and exercised and signed by each entry, for two of the ple. (Residents #1 and exercised and approximately 3:18 at approximately 3:18 at approximately 3:18 at approximately 3:18 at Review of the Residents. Review of the Residents.	and entry. e records ach he two nd #2) d to sign Nurse 00 PM hy sident	l 291	The RN has placed a post-duted s quarterly nursing examinations. It sheet that the RN signs for each q	here is an associal	ted	
b or re	review dated Octobesigned. D. Interview with the properties of th	revealed a nursing quer 22, 2008 that was read a facility's Registered 13 at approximately 11 RN) completed quarter is. Review of the Reservealed a nursing querous and the revealed a nursing querier as a facility of the Reservealed a nursing querier as a facility of the Reservealed a nursing querier as a facility of the Reservealed a nursing querier as a facility of the Reservealed a nursing querier as a facility of the Reservealed a nursing querier as a facility of the Reservealed a nursing querier as a facility of the Reservealed a nursing querier as a facility of the Reservealed as a facility of the Reservealed a nursing querier as a facility of the Reservealed a nursing querier as a facility of the Reservealed a nursing querier as a facility of the Reservealed as a facility of	Nurse :00 AM		signed that sheet (see: attached), instructed to insure that she routing review document itself 12-2-08. The QMRP will review the mediansure routine compliance 12-1. The IXON will also audit the median periodically 12-1-08.	nowever, the RN hally signs the quare cal records monthle 08.	as been terly	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI HFD03-0181		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE S COMPLE	
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l 291	Continued From pareview dated Augusigned.	age 8 st 18, 2008 that was	not	l 291			
	After medical services have been secured, each GHMRP shall promptly notify the resident 's guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident 's status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) one of the five residents in the sample. (Resident #5)			1374	The family of Client #5 was noticited here and in fact did visit he MTS staff failed to indicate the report. The QMRP will review a they are submitted to insure that notifications occur and are documprovide a second cross check before.	r in the bospital the potification on the ill incident reports the all appropriate mented. The IMC se	ereafter, incident " Defore Will
	entrance conferen Retardation Profes Resident #5 had a Review of the facil and investigative r beginning at 10:20 failed to notify Res of the following inc On July 28, 2008, right side of Resid	008 at 9:15 AM, during ce with the Qualified ssional (QMRP) reveality's unusual incident eports on October 250 AM, revealed that the sident #5's family imposted that the sident family imposted the sident #5's family imposted that the sident #5's family imposted that the sident family imposted that the sident family imposted the sident family imposted the sident family imposted that the sident family imposted the sident family imposted the sident family imposted the sident family imposted the sident family imposted the sident family imposted the sident family imposted the sident family imposted the sident family imposted the sident family imposted the sident family impo	Mental aled that lent. t reports 7, 2008 he facility hediately elling on the				

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NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	ADDRESS, CITY, STATE, ZIP CODE					
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I 374	Continued From paresident's family had aforementioned income	ad been notified of the	=	1374					
. 1379	each GHMRP shall Health, Health Fac- unusual incident or interferes with a re- arrangement, well I	POOLES Proporting requirement I notify the Departme Ilities Division of any revent which substart sident 's health, welf being or in any other t at risk. Such notifica	nt of other itially are, living way	1379		•			
	This Statute is not Based on interview GHMRP failed to e origin are reported and government ag	one immediately and ten notification within ours or the next work of met as evidenced by and record review, to the facility's admirgencies as required by MR Chapter 35 Sections.	day. /: he unknown histrator by DC		Staff was retrained on inciden will be trained at least once postaff meetings 12-15-UK.	t reporting on 10-3 r quarter during m	0-08 and		
	October 29, 2008, revealed an incider June 9, 2008. Acc discovered swelling face. 2. Review of the R October 29, 2008 a	le: acility's incident report beginning at 10:20 A nt involving Resident ording to the report, s g of Resident #5's jav tesident #1's medical at approximately 2:00 ring injury of unknown	M #5 dated staff v and record on PM,	•					
W. C.		sing progress note da							

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Health Re	egulation Administra	ation		,			· · · · · · · · · · · · · · · · · · ·
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM HFD03-0181		(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		(X3) DATE SUI COMPLET	
NAME OF D	ROVIDER OR SUPPLIER	111 000-0101	STREET ADD	RESS CITY S	TATE, ZIP CODE	10/31	/2000
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I 379	Continued From pa	age 10 that staff discovered	a bruise	1379			
-	on Resident #1's le interview and recor that the injury of ur	eft foot below the knew of review revealed no hknown origin as repo Health as required.	e, Further evidence				-
l 422	•	TION AND TRAINING	;	1 422			-
	Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident 's Individual Habilitation Plan.						٠
	This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide training and assistance to residents in accordance with the their Individual Habilitation Plans for one of the two residents included in the sample. (Resident #1)						-
	The findings includ	de:					
	2008 at 10:00 AM Individual Support Interview with the Professional (QMI	nt #1's records on Od revealed the resident Plan (ISP) dated July Qualified Mental Reta RP) on October 30, 2 her review of Resider	t had an y 18, 2008. ardation 008 at		The protocol needed for the proper i	aplementation	of the
	record revealed at the Interdisciplinar the following progr	t the time of the ISP r ry Team (IDT) recom ram objectives:	neeting,		lingual strengthening and labial strengthening and labial strengthening and labial strengthening the speech programmer of the strengthening and the simplement of the strengthening and strength	nthologist. They	will be .
	strengthening exe bolus formation to three consecutive	·	ng over		The programs will be implemented The QMRIP was aware of the need t line but was having difficulty gettin to provide the needed protocols and systems. In the future, the QMRP w	o get the progra g the speech pat data collection	inologist
Hoalth Regu	exercises in 10/10	will perform labial stre trials to improve bol are for swallowing ove hs.	us		of the Executive Director to move a timelier manner 12-20-08.		

Health Regulation Administration

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STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	(X3) DATE SURVEY COMPLETED				
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NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	ADDRESS, CITY, STATE, ZIP CODE					
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1 422	Continued From pa	ige 11		1422					
	resident's records of approximately 11:0 that the aforementic	QMRP and review of to on October 30, 2008 0 AM, there was no co oned program object titated or implemente	at evidence ives had				1		
1 430	3521.7(a) HABILITA	ATION AND TRAINI	VG	1 430		,			
	The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:								
	(a) Eating and drinking (including table manners, use of adaptive equipment, and use of appropriate utensils);								
	This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to train residents to develop strengthening exercises to improve bolus formation in prepariong for swallowing, for one of the two residents in the sample. (Resident #1)								
	The findings include	e:							
	Review of Resident #1's records on October 30, 2008 at 10:00 AM revealed the resident had an Individual Support Plan (ISP) dated July 18, 2008. Interview with the Qualified Mental Retardation Professional (QMRP) on October 30, 2008 at 10:30 AM and further review of Resident #1's record revealed that at the time of the ISP meeting, the Interdisciplinary Team (IDT) recommended the following program objectives: a. [the resident], will perform lingual				The protocol needed for the proper in lingual strengthening and labial strengthening and labial strengthening and labial strengthening and labial strengthening and the speech pattern to the speech pattern will be trained on the implementation 12-8-08. The programs will be implemented by The QMRP was aware of the need to pline but was having difficulty getting to provide the needed protocols and disystems. In the future, the QMRP will of the Executive Director to move suc	thening exercises had tologist. They will be ation strategies12-20-08. Set the programs on the speech pathologist at collection seek the assistance.			
	strengthening exerciple bolus formation to p	cises in 10/10 trials to prepare for swallowin	improve g over		timelier manner12-20-08.	t usks along in a			
ealth Regul: TATE COOL	ation Administration								

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Health R	egulation Administra	a <u>tion</u>				FURIN A	(PPROVED,
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SU COMPLET	TED
		HFD03-0181	CTOEST 400	20500 0074		10/31	/2008
NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
I 430	Continued From pa	age 12		1430			
	three personalities	mantha: and					
	three consecutive r	monus, and					į
	 b. [the resident], will perform labial strengthening exercises in 10/10 trials to improve bolus formation to prepare for swallowing over three consecutive months. 						
	A	MDD and and an income 14					
		MRP and review of the failed to provide evident					1
		d program objectives		'			ĺ
_	developed, initiated		IIGU DÇÇII				
	doroloped, middlet	o or mpremen.				ļ	ŀ
i 484	3522.11 MEDICAT	TIONS		1 484			
; ;	medication that is	Il promptly destroy prodiscontinued by the period expiration date, or high label.	hysician	•			
	This Statute is not	t met as evidenced by	r.				
		tion, interview and red				'	
•		failed to promptly des					٠
		tion that was disconti					
		hysician for one of the					
		in the sample. (Resi					
	The finding include	es:					
	October 29, 2008 a	nedication supply cab at 9:10 AM, revealed ge of Klonopin 0.5 mg	a				
		nt #1. Interview with t			MIS medication disposal policy m	ust be revised to	<u> </u>
1		at 9:15 AM indicated			climinate the instruction to flush suc pharmacy does not take back contro		
		scontinued around Au			policy will be revised to instruct nor	ned medication	7 W19.
		rview indicated that the			sprinkle such medications and disca-	rd them in the t	rash in
		have been returned			that form. This plus properly docum	enting the actio	ns will
		d verification on Octo			be the MTS practice going forward.	12-15-08.	
		revealed a physician]
		2008, to "Stop Klonop					
) .		ication was still store	in the				
neann Kegu	lation Administration						

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REGULATORY OR LSC IDENTIFYING INFORMATION) 1484 Continued From page 13 medication cabinet as of October 29, 2008. 1500 Secondary or Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure clients were not subjected to verbal, physical and psychologoical abuse and mistreatment, for two of the five residents that resided in the facility. (Residents #2 and #3) The findings Include: 1. On October 29, 2008 at 7:18 AM during breakfast observations, Direct Care Staff (DCS) #13 was observed forcefully feeding and talking harshly to Client #3. DCS #13 was observed standing with her body next to the client's head and shoulder. At the same time, DCS #13's right arm was wrapped over the client's head and her hand was under the client's head and her hand was under the client's head and her hand was under the client's head and her hand was under the client's chin (head lock position). DCS #13 was overheard saying to Client #3, "Eat, I don't have all day, I have a lot to do today." At 7:30 AM, DCS #13 indicated to the surveyor that Client #3 was very difficult to feed, At 7:31 AM, DCS #13 indicated to the surveyor that Client #3 was very difficult to feed, At 7:31 AM, DCS #13 indicated to the surveyor that Client #3 was very difficult to feed.	Health R	egulation Administra	<u>ation</u>				FURIM A	4PPKOVĖD∃
MTS STREET ADDRESS, CITY, STATE, ZIP CODE 44/14-16 JAY STREET, NE ASSIMBARY STATEMENT OF DETICIENCE BY REGULATORY OR LSC IDENTIFYING INFORMATION) 1 484 Continued From page 13 medication cabinet as of October 29, 2008, 1 500 Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that systems were designed and implemented to ensure clients were not subjected to verbal, physical and psychological abuse and mistreatment, for two of the five residents that resided in the facility. (Residents #2 and #3) The findings include: 1. On October 29, 2008 at 7:18 AM during breakfast observations, Direct Care Staff (DCS) #13 was observed standing with her body next to the client's head and shoulder. At the same time, DCS #13's right arm was wrapped over the client's head and was under the client's chin (head lock position). DCS #13 was everheard saying to Client #3, "Eat, I don't have all day, I have a lot to do today." At 7:30 AM, DCS #13 indicated to the surveyor that Client #3 was was everyor that Client #3 was was everyor that Client #3 was was were yellow to feed. At 7:31 AM, DCS #13 said to Client #3, "Eat, I don't have all dot, I have a lot to do today." At 7:30 AM, DCS #13 indicated to the surveyor that Client #3 was was very direct to the surveyor that Client #3 was were yellow to feed. At 7:31 AM, DCS #13 said to Client #3, "Eat, I don't have all dot, I have a lot to do today." At 7:30 AM, DCS #13 said to Client #3, "Eat, I don't have said to Client #3, "Eat, I don't have said to Client #3, "Eat, I don't have said to Client #3, "Eat, I don't have said to Client #3, "Eat, I don't have said to Client #3, "Eat, I don't have said to Client #3, "Eat, I don't have said to Client #3, "Eat, I don't have said to Client #3, "Eat, I don't have said to Client #3, "Eat,			IDENTIFICATION NUI		A BUILDIN		COMPLE	TED
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FREETY TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 1484 Continued From page 13				4414-16 J	AY STREET	. NE		* !
medication cabinet as of October 29, 2008. 1500 Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on interview and record review, the facility falled to ensure that systems were designed and implemented to ensure clients were not subjected to verbal, physical and psychological abuse and mistreatment, for two of the five residents that resided in the facility. (Residents #2 and #3) The findings include: 1. On October 29, 2008 at 7:18 AM during breakfast observed forcefully feeding and talking harshly to Client #3. DCS #13 was observed standing with her body next to the client's head and her hand was under the client's head and her hand was under the client's chin (head lock position). DCS #13 was overheard saying to Client #3, "Eat, I don't have all day, I have a lot to do today." At 7:30 AM, DCS #13 indicated to the surveyor that Client *3 was very difficult to feed, At 7:31 AM, DCS #13 said to Client *3, "Open	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	illiti a.e.	(XS) COMPLETE DATE
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that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that systems were designed and implemented to ensure clients were not subjected to verbal, physical and psychological abuse and mistreatment, for two of the five residents that resided in the facility. (Residents #2 and #3) The findings include: 1. On October 29, 2008 at 7:18 AM during breakfast observations, Direct Care Staff (DCS) #13 was observed forcefully feeding and talking harshly to Client #3. DCS #13 was observed standing with her body next to the client's head and shoulder. At the same time, DCS #13's right arm was wrapped over the client's head and her hand was under the client's chin (head lock position). DCS #13 was overheard saying to Client #3, "Eat, I don't have all day, I have a lot to do today." At 7:30 AM, DCS #13 indicated to the surveyor that Client #3 was very difficult to feed, At 7:31 AM, DCS #13 said to Client #3, "Open	1 500	3523,1 RESIDENT	"\$ RIGHTS		I 500)
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1. On October 29, 2008 at: 7:18 AM during breakfast observations, Direct Care Staff (DCS) #13 was observed forcefully feeding and talking harshly to Client #3. DCS #13 was observed standing with her body next to the client's head and shoulder. At the same time, DCS #13's right arm was wrapped over the client's head and her hand was under the client's chin (head lock position). DCS #13 was overheard saying to Client #3, "Eat, I don't have all day, I have a lot to do today." At 7:30 AM, DCS #13 indicated to the surveyor that Client #3 was very difficult to feed, At 7:31 AM, DCS #13 said to Client #3, "Open		Based on interview failed to ensure the implemented to ensure to verbal, physical amistreatment, for the	wand record review, at systems were designated as sure clients were not and psycholgoical ab wo of the five residen	the facility gned and subjected use and its that				
breakfast observations, Direct Care Staff (DCS) #13 was observed forcefully feeding and talking harshly to Client #3. DCS #13 was observed standing with her body next to the client's head and shoulder. At the same time, DCS #13's right arm was wrapped over the client's head and her hand was under the client's chin (head lock position). DCS #13 was overheard saying to Client #3, "Eat, I don't have all day, I have a lot to do today." At 7:30 AM, DCS #13 indicated to the surveyor that Client #3 was very difficult to feed, At 7:31 AM, DCS #13 said to Client #3, "Open		The findings includ	le:			19		
your mouth you know you like the food." DCS #13 was then observed forcefully sticking the spoon into the client mouth. 2. On October 29, 2008 at 7:15 AM, Client #2		breakfast observati #13 was observed harshly to Client #3 standing with her b and shoulder. At the arm was wrapped of hand was under the position). DCS #13 Client #3, "Eat, I do do today." At 7:30 surveyor that Client At 7:31 AM, DCS # your mouth you know #13 was then obse spoon into the client	ions, Direct Care State forcefully feeding and DCS #13 was obstand next to the client he same time, DCS # over the client's head e client's chin (head is 3 was overheard say) on't have all day, I have AM, DCS #13 indicated the factor of the the food. Served forcefully sticking the mouth.	ff (DCS) d talking erved 's head f13's right l and her lock ing to ve a lot to ted to the to feed, "Open ' DCS ng the		to force feed client #3 was terminated	d based on	
2. On October 29, 2008 at 7:15 AM, Client #2 was observed independently eating eggs. After	lealth Regul	was observed inde						

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI HFD03-0181		(X2) MULTI A. BUILDIN B. WING		(X3) DATE SI COMPLE		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE	10/3	1/2000	
MTS				JAY STREET, NE STON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD RE	(XS) COMPLETE DATE	
. 500	DCS #13 verbally processed to place it mouthing). At 7:42 feed Client #2. The refused by turning At 7:46 AM, DCS # client. Again the client. Again the client abottle of Boost Platt the time of the additional and immediate jeopard following: - the alleged abuse leaving pending the cape of the additional alleged abuse were alleged	ps, the client stopped prompted Client #2 to be client refused and her hand into her more AM, DCS #13 attempted to feed the client was observed her head away from the client refused. At 7:48 putting the client's fo 3 then provided the controllers to the client of the	ws uth (hand pted to i to i to the spoon. I the AM, DCS od down lient with vations, n table acility and ober 29, House formed the the d an wi, the n to lift the d of the hinistrative stigation; the rative	1500	The two other staff members on duty retrained on reporting and addressing other serious reportable incident situ to duty 12-2-08. It should be noted that both the QMI Manager observe meal implementati and both report that they have never from the staff member terminated no should also be noted that the two stated during their investigation into ever seen the terminated staff member provide such inappropriate meals. The QMRP and Facility Man observe meals for all shifts at minimand will provide on the spot training follow established protocols 12-13 in addition, the in-home staff orient to insure that mealtime protocols are orientation 12-15-08. b. Client #2 has a mealtime her support needs when experiodic tendency to refus food presented to her. As surveyor, client #2 are her the remainder of the meal the surveyor, client #2 be staff attempted to assist herefused and at 7:48 mg, 33 started the meal, the staff remainder of the meal. Cliptotocol will be revised to how staff is to address religious of a meal or an experions of a meal or an experion of this deficiency frequent behavior but rail Client #2 usually eats we	g abuse/neglect ations before n RP and the Faci ion on a routine seen such beha or any other sta If members on rviews that nei- er or any other "assistance" du auge will continum once week g when staff fai i-08, ation will be me e trained during protocol that aid ating but not he the some or all o indicated by th r eggs and then As also ment gan the meal at er several times i minutes after "member disease inent #2's mealt of add instruction itsels to cat cer attire meal. The all indicated d report that this her an infreque	and eturning slifty chasts avior II. It duty ther had staff aring nue to ly each I to wiffed a the slifted to the time erefused ioned by 1.7:15am, s but was client #2 redd the time ans on rtain c QMRP, luring the is not a	
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Health R	egulation Administra	ation		· · · · · · · · · · · · · · · · · · ·		Y			
AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED 10/31/2008			
					DRESS, CITY, STATE, ZIP CODE				
4414-16 JA					AY STREET, NE TON, DC 20019				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	SHOULD BE COMPLETE			
1500	Continued From page 15 and - all remaining staff will be in-serviced by October 31, 2008 on abuse and neglect, incident reporting, mealtime protocols, and Client #2's Behavior Support Plan (BSP). [It should be noted that the surveyor remained onsite until the facility put systems in place to remove the immediate jeopardy.] 3. The facility failed to ensure that informed consent was obtained from Client #2 and/or her legal guardian prior to the administration of her psychotropic medications. Observation of the morning medication administration on October 29, 2008, at 8:48 AM revealed Client #2 was administered Prozac HCL 40 mg, Naltrexone Hydrochlonde 50 mg and Megestrol Acetate 10 ml. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the client's hand sucking behavior. During the entrance conference on October 294, 2008, an interview was conducted with the Qualified Mental Retardation Professional			1 500	The mealtime protocol will be revised by12-15-08. Staff will be retrained on the revised program by12-20- 08. The revised program will be implemented by12-27-08. It should also be noted that it is the individual's right to refuse unwanted treatment and that includes an occasional meal or portions of a meal. The protocol will be modified with respect for that right in mind but will provide strategies that maximize the likelihood of getting client #2 to consume her entire meal via positive reinforcement and respecting her right to chaose (for example, by not serving her foods that she clearly dislikes)12-15-08. Client #2's legal guardian (mother) did sign consents for the psychotropic drug regimen and the behavior support plan on 12-7-07 (See: attached copies)12-2-08. MTS will utilize the new standard DDA forms to review and update Client #2's mother on the psychotropic drug				
	#2 did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on October 30, 2008, at 3:30 PM through review of Client #1's psychological assessment dated June 13, 2008. According to the assessment, Client #2 "is not able to make independent decisions concerning her residential or day placements. She lacks the cognitive skills necessary to understand the implications of such				regimen and BSP12-15-08. Thereafter, MTS will insure that a ris is held and consent is obtained for any psychotropic drug regimen or the BSI	ks/henelits discussion y changes in the			

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Health Regulation Administration

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
HFD03-0181				B. WING _		10/3	10/31/2008		
ı				DRESS, CITY, STATE, ZIP CODE					
MTS			WASHINGT	IAY STREET, NE STON, DC 20019					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)			
	consent. She lacks required to make do QMRP further reversamily involvement making. Review of the client additional interview 30, 2008, at 3:06 Pt that Client #2's treat benefits and potent her medications, ar	efore cannot give here the judgment and in ecisions independent aled the client had act to assist her in decis I's medical record an with the QMRP on C M failed to provide extreent needs, includit ial side effects associated the right to refuse m explained to her an	informed asight the stive ion ctober vidence ag the stated with	1 500					
lealth Receive	ation Administration	···-	<u></u>	<u> </u>					
TATE FORM			bos	P M	IOY011	If continuatio	in sheet 17 of 17		